Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Henrik Mike-Mayer MD

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-14-2232-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We contacted the adjuster, Jennifer Patton, on 6/14/13, and she told us that no pre auth was needed for the brace. She verbally provided reasonable and necessary authorization for patient's thoracic x-rays and brace."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2013	L0472	$800.00	$485.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor meet pre authorization guidelines?
2. What is the rule that determines reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on April 1, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. Per 28 Texas Administrative Code §134.600 (f) "The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission." 28 Texas Administrative Code §134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);" Review of the submitted documentation finds;
    a. Office record from requestor dated, June 14, 2013, that states, "Spoke with Jennifer Patton, patient's adjustor and she provided reasonable and necessary authorization for her thoracic x-rays and Cruciform brace."

   The carrier's denial is not supported as requestor did meet requirements of Rule 134.600(f) and based on documentation the requestor did receive an authorization thus meeting Rule 134.600(p). The disputed service will be reviewed per applicable rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.203 (d) "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;" Per the Durable Medical Equipment Medicare Pricing, Data Analysis and Coding contractor (PDAC) found at, https://www.dmepdac.com, the allowable for the submitted code L0472 is $388.51. This amount multiplied by 125% will equal MAR or (388.51 x 125% = $485.64).
4. The Maximum allowable reimbursement is $485.64. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $485.64.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $485.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January , 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.